NewYork-Presbyterian Queens

SCARBOROUGH, WILLIAM

68 Y old Male, DOB: [redacted] External MRN: [redacted]
Account Number: [redacted]
Guarantor: SCARBOROUGH, WILLIAM
Insurance: EMPIRE BC/BS NY - BLSH Payer ID: SB803
PCP: Sanford Bruce Ratner Referring: Rajeev Dayal
Appointment Facility: NYQMS CARDIO PRACTICE

12/11/2014

Progress Notes: Chong H. Park, MD, FACC

Current Medications

Taking
- Norvasc 10 MG Tablet 1 tablet Once a day
- Simvastatin 10 MG Tablet 1 tablet in the evening Once a day
- Allopurinol 300 MG Tablet 1 tablet Once a day
- Plavix 75 MG Tablet 1 tablet Once a day
- Metformin HCl 500 MG Tablet 1 tablet with meals Twice a day
- Accupril 40 MG Tablet 1 tablet Once a day
- Medication List reviewed and reconciled with the patient

Active Problem List

250.00 Diabetes mellitus

447.9 Carotid artery disease

V15.82 Tobacco abuse, in remission

401.9 HTN (hypertension)

V72.84 Pre-op evaluation

794.31 Abnormal ECG

Past Medical History

HTN (hypertension)
Diabetes mellitus
Carotid artery disease
Tobacco abuse, in remission

Surgical History

Lumbar laminectomy 2/2010

Family History

Father: deceased 60 yrs, diagnosed with Cancer
Mother: deceased 84 yrs, diagnosed with Heart Disease in 75

Social History

Tobacco Use:
Tobacco Use/Smoking
What is your current smoking status?

Reason for Appointment

1. Clearance

History of Present Illness

Diet/Exercise:
Exercise walking.

Interval History:
Comments: 68 year old male with HTN, DM, Former Tobacco, with recent TIA with work up revealing high grade stenosis of Right Carotid. Initially seen for claudication, and recent with complaints of headache with left sided numbness approximately 2 weeks ago. Could not speak. Went to ER. CT Scan and Brain MRA/MRI. Right ICA with 95%. Patient denies complaints of CP, shortness of breath, syncopal or near syncopal episodes, PND, orthopnea, palpitation, or edema. Has history of abnnormal ECG, and gets annual stress testing in Albany. Reportedly normal. Last one was in 5/6/14, with 7 min Bruce Protocol exercise capacity, non-diagnostic ECG changes due to baseline abnormalities, and normal LV function without reional wall motion abnormalities.

Vital Signs

Ht 72, Wt 198, BMI 26.85, RR 14, BP left arm 154/78, BP right arm 148/72.

Examination

General Examination:
GENERAL APPEARANCE: male, alert and oriented, no acute distress, well hydrated, well nourished.
Cardiovascular:
PMI nl and not displaced.
Auscultation nl , S1, S2, regular, no S3, no S4.
Murmurs none.
Carotids Right Carotid bruit.
Abdomen Aorta normal, non pulsatile, no bruit.
Femoral Arteries normal, pulses, no bruit, no hematoma.
Pedal Pulses posterior tibialis, dorsalis pedis, 2+, 1+.
Edema None.

former smoker
How long has it been since you last smoked? *> 10 years*
Additional Findings: Tobacco User *Heavy cigarette smoker (20-39 cigs/day)*

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Lumbar laminectomy 2/2010

Review of Systems
General/Constitutional:
Fatigue denies. Fever denies. Headache denies. Weight gain denies.
Integumentary:
Rash Denies. Itching Denies. Color Change Denies.
Eyes:
Visual changes Denies.
ENT:
Ear pain denies. Drainage Denies. Mouth Sores Denies.
Endocrine:
Excessive thirst denies.
Respiratory:
Asthma Denies. Cough denies. Hemoptysis denies. Wheezing denies.
Cardiovascular:
Dyspnea on exertion denies. Lightheadedness Denies. Loss of consciousness Denies. Palpitations denies. CP-Pressure Denies. Edema Denies.
Gastrointestinal:
Dysphagia Denies. Blood in stool denies. Change in bowel habits denies. Decreased appetite denies.

Hematology:
Bruising Denies.
Genitourinary:
Blood in urine denies. Difficulty urinating denies. Impotence Denies.
Musculoskeletal:
Leg cramps denies. Painful joints denies. Swollen joints denies. Weakness denies.
Neurologic:
TIA/Stroke Denies. Parasthesia Denies. Dizziness denies. Seizures denies.
Psychiatric:
Confusion Denies. Memory Loss Denies. Depressed mood denies.

Dermatology:
EXTREMITIES: Within Normal Limits: Inspection and/or palpation of digits (clubbing, cyanosis, inflammation, ischemia).
SKIN: Within Normal Limits: Inspection and/or palpation of skin and subcutaneous tissue (ulcers,scars,stasis dermatitis, xanthomas).
Psychiatry:
ORIENTATION: Within Normal Limits to time, place and people:.
AFFECT: appropriate.
Musculoskeletal:
Gait Within Normal Limits: Assessment of ability to undergo exercise testing and/or participate in exercise program.
Respiratory:
Lungs Good inspiratory effort, Clear to Auscultation, No Wheezing , No Rales.
Neurological:
MENTAL STATUS EXAMINATION normal.
Neck:
NECK: Exam of jugular veins (distention; a,v or cannon a waves) is normal with normal ROM.
Oral/Oropharynx:
NORMAL - ORAL/OROPHARYNX: within normal limits of inspection of oral mucosa with notation of presence of pollor or cyanosis.
Gastrointestinal:
Abdomen/GI Within Normal Limits: Soft, benign, non-tender, no bruit.
Ophthalmology:
CONJUNCTIVA: within normal limitsof inspection of conjunctivae and lids.
EKG (Structured):
Rhythm: Normal Sinus.
Rate:

74

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Axis: Normal.
Intervals: :.
Ischemia/Infarction: Inferior Ischemia.

Assessments
1. Pre-op evaluation - V72.84 (Primary), 5/6/14, with 7 min Bruce Protocol exercise capacity, non-diagnostic ECG changes due to baseline abnormalities, and normal LV function without reional wall motion abnormalities
2. Diabetes mellitus - 250.00
3. Carotid artery disease - 447.9
4. Tobacco abuse, in remission - V15.82
5. HTN (hypertension) - 401.9
6. Abnormal ECG - 794.31

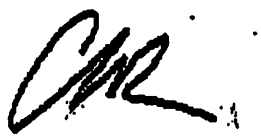
Mr. Scarborough presents today with recent TIA and severe right ICA stenosis, and is scheduled for a right CEA. Although he has t wave

inversions in the inferior leads, He has a non-ischemic stress Echo performed in May. He has no active angina. He has no suggestion of CHF. His CEA is medically necessary and of urgent need. He is at intermediate cardiac risk, for peri-operative CV events. He does not need further ischemic evaluation, and he does not have a cardiac contraindication to proceed onward. He is to continue his current medicines peri-op.

Treatment
1. Others
Notes: Continue current therapy
Exercise - graduated plan reviewed, increase as tolerated.

Procedure Codes
93000 EKG GLOBAL

Follow Up
3 Months



Electronically signed by CHONG PARK , MD on 12/11/2014 at 02:26 PM EST

Sign off status: Completed

NYQMS CARDIO PRACTICE
56-45 Main Street
Flushing, NY 113555045
Tel: 718-670-2087
Fax: 718-661-7708

NewYork-Presbyterian
Queens

SCARBOROUGH, WILLIAM

68 Y old Male, DOB: [redacted]; External MRN: [redacted]
Account Number: [redacted]
Guarantor: SCARBOROUGH, WILLIAM
Insurance: EMPIRE BC/BS NY - BLSH Payer ID: SB803
PCP: Sanford Bruce Ratner Referring: Sanford Bruce Ratner
Appointment Facility: NYQMS CARDIO PRACTICE

03/12/2015

Progress Notes: Chong H. Park, MD, FACC

Current Medications

Taking
- Norvasc 10 MG Tablet 1 tablet Once a day
- Simvastatin 10 MG Tablet 1 tablet in the evening Once a day
- Allopurinol 300 MG Tablet 1 tablet Once a day
- Plavix 75 MG Tablet 1 tablet Once a day
- Metformin HCl 500 MG Tablet 1 tablet with meals Twice a day
- Accupril 40 MG Tablet 1 tablet Once a day

Active Problem List

250.00 Diabetes mellitus

447.9 Carotid artery disease

V15.82 Tobacco abuse, in remission

401.9 HTN (hypertension)

V72.84 Pre-op evaluation

794.31 Abnormal ECG

Past Medical History

HTN (hypertension)
Diabetes mellitus
Carotid artery disease
Tobacco abuse, in remission

Surgical History

Lumbar laminectomy 2/2010

Family History

Father: deceased 60 yrs, diagnosed with Cancer
Mother: deceased 84 yrs, diagnosed with Heart Disease in 75

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

Reason for Appointment

1. 3 month f/u

History of Present Illness

Diet/Exercise:
Exercise walking, treadmill.

Interval History:
Comments: Underwent successful Right CEA. Patient denies complaints of CP, shortness of breath, syncopal or near syncopal episodes, PND, orthopnea, palpitation, or edema. Loss of 5 lbs since last visit. Notes mild dyspnea when he has a full stomach, but otherwise no exertional dyspnea. Notes low back discomfort. Reportedly had unsuccessful PTA effort of his lower extremities. Notes intermittent claudication, when walking a block, but none when he uses a treadmill.

Vital Signs

Ht 72, Wt 193, BMI 26.17, BP 112/56 mm Hg, HR 94, RR 16.

Examination

General Examination:
GENERAL APPEARANCE: male, alert and oriented, no acute distress, well hydrated, well nourished.
Cardiovascular:
PMI nl and not displaced.
Auscultation nl , S1, S2, regular, no S3, no S4.
Murmurs none.
Carotids normal, no bruit, Right CEA scar.
Abdomen Aorta normal, non pulsatile, no bruit.
Femoral Arteries normal, pulses, no bruit, no hematoma.
Pedal Pulses posterior tibialis, dorsalis pedis, 2+, 1+.
Edema None.
Dermatology:
EXTREMITIES: Within Normal Limits: Inspection and/or palpation of digits (clubbing, cyanosis, inflammation, ischemia).
SKIN: Within Normal Limits: Inspection and/or palpation of skin and subcutaneous tissue (ulcers,scars,stasis dermatitis, xanthomas).

Lumbar laminectomy 2/2010

Review of Systems

General/Constitutional:
Fatigue denies. Fever denies. Headache denies. Weight gain denies.
Integumentary:
Rash Denies. Itching Denies. Color Change Denies.
Eyes:
Visual changes Denies.
ENT:
Ear pain denies. Drainage Denies. Mouth Sores Denies.
Endocrine:
Excessive thirst denies.
Respiratory:
Asthma Denies. Cough denies. Hemoptysis denies. Wheezing denies.
Cardiovascular:
Dyspnea on exertion denies. Lightheadedness Denies. Loss of consciousness Denies. Palpitations denies. CP-Pressure Denies. Edema Denies.
Gastrointestinal:
Dysphagia Denies. Blood in stool denies. Change in bowel habits denies. Decreased appetite denies.

Hematology:
Bruising Denies.
Genitourinary:
Blood in urine denies. Difficulty urinating denies. Impotence Denies.
Musculoskeletal:
Leg cramps denies. Painful joints denies. Swollen joints denies. Weakness denies.
Neurologic:
TIA/Stroke Denies. Parasthesia Denies. Dizziness denies. Seizures denies.
Psychiatric:
Confusion Denies. Memory Loss Denies. Depressed mood denies.

Psychiatry:
ORIENTATION: Within Normal Limits to time, place and people:.
AFFECT: appropriate.
Musculoskeletal:
Gait Within Normal Limits: Assessment of ability to undergo exercise testing and/or participate in exercise program.
Respiratory:
Lungs Good inspiratory effort, Clear to Auscultation, No Wheezing , No Rales.
Neurological:
MENTAL STATUS EXAMINATION normal.
Neck:
NECK: Exam of jugular veins (distention; a,v or cannon a waves) is normal with normal ROM.
Oral/Oropharynx:
NORMAL - ORAL/OROPHARYNX: within normal limits of inspection of oral mucosa with notation of presence of pollor or cyanosis.
Gastrointestinal:
Abdomen/GI Within Normal Limits: Soft, benign, non-tender, no bruit.
Ophthalmology:
CONJUNCTIVA: within normal limitsof inspection of conjunctivae and lids.
EKG (Structured):
Rhythm: Normal Sinus.
Rate:

94

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Axis: Normal.
Intervals: :.
Ischemia/Infarction: Inferior Ischemia.

Assessments

1. Abnormal ECG - 794.31 (Primary)
2. Diabetes mellitus - 250.00
3. Carotid artery disease - 447.9
4. Tobacco abuse, in remission - V15.82
5. HTN (hypertension) - 401.9
6. Pre-op evaluation - V72.84, 5/6/14, with 7 min Bruce Protocol exercise capacity, non-diagnostic ECG changes due to baseline abnormalities, and normal LV function without reional wall motion abnormalities

Mr. Scarborough is without angina or dyspnea. Although he has baseline ECG abnormalities, his stress testing is noted to be non-ischemic. Additionally, he has no angina. Will therefore follow him clinically. I have asked that he continue with current medicines.

Treatment

1. Others

Notes: Continue current therapy
Exercise - graduated plan reviewed, increase as tolerated.

Procedure Codes
93000 EKG GLOBAL

Follow Up
6 Months

Electronically signed by CHONG PARK , MD on 03/12/2015 at 05:27 PM EDT

Sign off status: Completed

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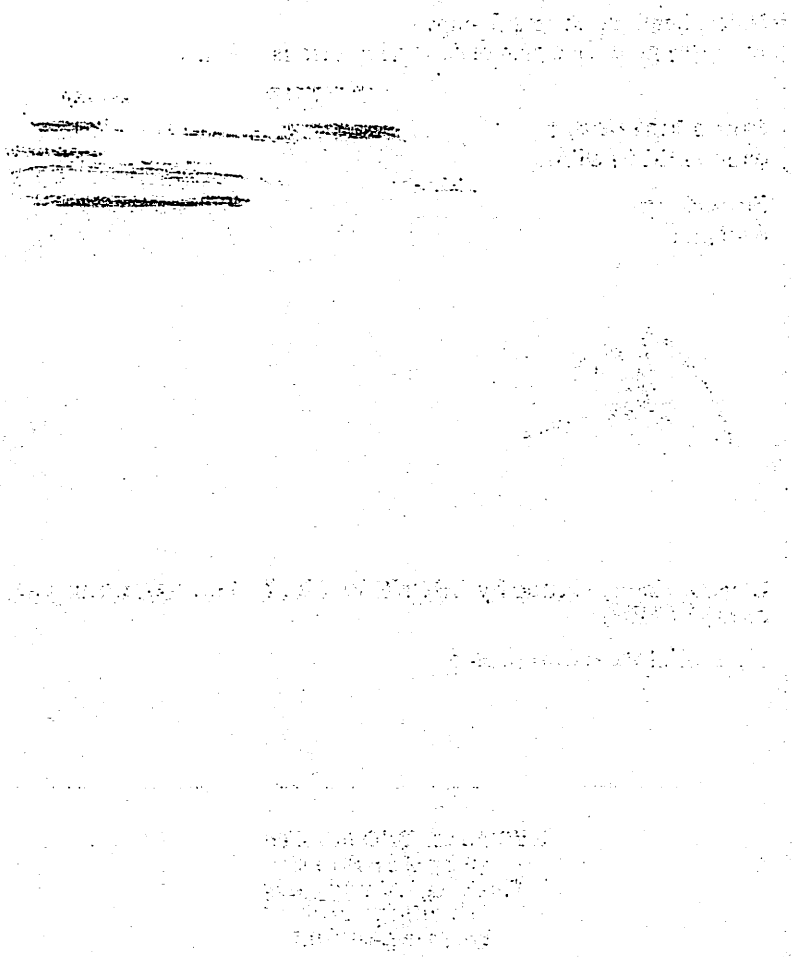

NewYork-Presbyterian Queens

SCARBOROUGH, WILLIAM

69 Y old Male, DOB: [redacted], External MRN: [redacted]
Account Number: [redacted]
[redacted]
Guarantor: SCARBOROUGH, WILLIAM Insurance: UHC - EMPIRE PLAN - NYEC Payer ID: 87726
PCP: Sanford Bruce Ratner Referring: Sanford Bruce Ratner
Appointment Facility: NYQMS CARDIO PRACTICE

04/24/2015 **Progress Notes: Chong H. Park, MD, FACC**

Current Medications

Taking
- Norvasc 10 MG Tablet 1 tablet Once a day
- Simvastatin 10 MG Tablet 1 tablet in the evening Once a day
- Allopurinol 300 MG Tablet 1 tablet Once a day
- Plavix 75 MG Tablet 1 tablet Once a day
- Metformin HCl 500 MG Tablet 1 tablet with meals Twice a day
- Accupril 40 MG Tablet 1 tablet Once a day
- Medication List reviewed and reconciled with the patient

Active Problem List

250.00 Diabetes mellitus

447.9 Carotid artery disease

V15.82 Tobacco abuse, in remission

401.9 HTN (hypertension)

V72.84 Pre-op evaluation

794.31 Abnormal ECG

785.1 Palpitations

Past Medical History

HTN (hypertension)
Diabetes mellitus
Carotid artery disease
Tobacco abuse, in remission

Surgical History

Lumbar laminectomy 2/2010

Family History

Father: deceased 60 yrs, diagnosed with Cancer
Mother: deceased 84 yrs, diagnosed with Heart Disease in 75

Social History

Tobacco Use:

Reason for Appointment

1. increase in BP and HR

History of Present Illness

Diet/Exercise:
Exercise walking, treadmill.

Interval History:
Comments: Noted daily palp over the last couple of weeks. Occurs in am as he awakens. No syncope, no dizziness. Has occastional headaches. No CP, no SOB. Noted SBP as high as 170's. Seen by Albany Medical Center ER and released after observation. There is one documented pulse of 115. No palp during day or night time. Been drinking more coffee lately and been stressed at work duties.

Vital Signs

Ht 72, Wt 190, BMI 25.77, BP 124/60 mm Hg, HR 79, RR 16.

Examination

General Examination:
GENERAL APPEARANCE: male, alert and oriented, no acute distress, well hydrated, well nourished.
Cardiovascular:
PMI nl and not displaced.
Auscultation nl , S1, S2, regular, no S3, no S4.
Murmurs none.
Carotids normal, no bruit, Right CEA scar.
Abdomen Aorta normal, non pulsatile, no bruit.
Femoral Arteries normal, pulses, no bruit, no hematoma.
Pedal Pulses posterior tibialis, dorsalis pedis, 2+, 1+.
Edema None.
Dermatology:
EXTREMITIES: Within Normal Limits: Inspection and/or palpation of digits (clubbing, cyanosis, inflammation, ischemia).
SKIN: Within Normal Limits: Inspection and/or palpation of skin and subcutaneous tissue (ulcers,scars,stasis dermatitis, xanthomas).
Psychiatry:
ORIENTATION: Within Normal Limits to time, place and people:.

Tobacco Use/Smoking
What is your current smoking status? *former smoker*
How long has it been since you last smoked? *> 10 years*
Additional Findings: Tobacco User *Heavy cigarette smoker (20-39 cigs/day)*

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Lumbar laminectomy 2/2010

Review of Systems

General/Constitutional:
Fatigue denies. Fever denies. Headache denies. Weight gain denies.
Integumentary:
Rash Denies. Itching Denies. Color Change Denies.
Eyes:
Visual changes Denies.
ENT:
Ear pain denies. Drainage Denies. Mouth Sores Denies.
Endocrine:
Excessive thirst denies.
Respiratory:
Asthma Denies. Cough denies. Hemoptysis denies. Wheezing denies.
Cardiovascular:
Dyspnea on exertion denies. Lightheadedness Denies. Loss of consciousness Denies. Palpitations admits to palpitations every morning. CP-Pressure Denies. Edema Denies.
Gastrointestinal:
Dysphagia Denies. Blood in stool denies. Change in bowel habits denies. Decreased appetite denies.

Hematology:
Bruising Denies.
Genitourinary:
Blood in urine denies. Difficulty urinating denies. Impotence Denies.
Musculoskeletal:
Leg cramps denies. Painful joints denies. Swollen joints denies. Weakness denies.
Neurologic:
TIA/Stroke Denies. Parasthesia Denies. Dizziness denies. Seizures denies.

AFFECT: appropriate.
Musculoskeletal:
Gait Within Normal Limits: Assessment of ability to undergo exercise testing and/or participate in exercise program.
Respiratory:
Lungs Good inspiratory effort, Clear to Auscultation, No Wheezing , No Rales.
Neurological:
MENTAL STATUS EXAMINATION normal.
Neck:
NECK: Exam of jugular veins (distention; a,v or cannon a waves) is normal with normal ROM.
Oral/Oropharynx:
NORMAL - ORAL/OROPHARYNX: within normal limits of inspection of oral mucosa with notation of presence of pollor or cyanosis.
Gastrointestinal:
Abdomen/GI Within Normal Limits: Soft, benign, non-tender, no bruit.
Ophthalmology:
CONJUNCTIVA: within normal limitsof inspection of conjunctivae and lids.
EKG (Structured):
Rhythm: Normal Sinus.
Rate: 79.
Axis: Normal.
Intervals: :.
Ischemia/Infarction: Inferior Ischemia.

Assessments
1. Palpitations - 785.1 (Primary)
2. Diabetes mellitus - 250.00
3. Carotid artery disease - 447.9
4. Tobacco abuse, in remission - V15.82
5. HTN (hypertension) - 401.9
6. Pre-op evaluation - V72.84, 5/6/14, with 7 min Bruce Protocol exercise capacity, non-diagnostic ECG changes due to baseline abnormalities, and normal LV function without reional wall motion abnormalities
7. Abnormal ECG - 794.31

Mr. Scarborough is noted to have daily palpitaitons, which seem to be more physiologic, i.e. Sinus Tachycardia. As he is noted to have episodes of elevated BP, will empirically try low dose Beta Blockade. If no relief, then will get Holter.

Treatment
1. Palpitations
Start Toprol XL Tablet Extended Release 24 Hour, 25 MG, 1 tablet, Orally, Once a day, 30 day(s), 30, Refills 6

Procedure Codes

Psychiatric:
Confusion Denies. Memory Loss Denies. Depressed mood denies.

93000 EKG GLOBAL

Follow Up
6 Months

Electronically signed by CHONG PARK , MD on 04/24/2015 at 05:05 PM EDT

Sign off status: Completed

NYQMS CARDIO PRACTICE
56-45 Main Street
Flushing, NY 113555045
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Patient: SCARBOROUGH, WILLIAM DOB: [redacted] Progress Note: Chong H. Park, MD, FACC 04/24/2015

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